## SYMPTON CHECKLIST

**Please indicate how often you have the following**

| | | | |
|---|---|---|---|
| Night sweats: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Hot flashes/hot flushes: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Pain with intercourse: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Vaginal dryness: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Sleeping problems: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Urine leaks when you cough or sneeze: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Difficulty concentrating/memory loss: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Mood swings: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Migraines: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Depression: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Anxiety: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Decease in sexual desire: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Decrease in energy level: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Loss of memory: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Foggy thinking: | ☐ Frequently | ☐ Rarely | ☐ Never |
| Muscle and/or joint pain: | ☐ Frequently | ☐ Rarely | ☐ Never |

**Please check the boxes below if they apply to how you have dealt with the above symptoms**

Herbal medications/supplements ☐ YES ☐ NO

Please specify how: ______________________________

Change of diet: ☐ YES ☐ NO

Please specify how: ______________________________

Layered clothing: ☐ YES ☐ NO

Please specify how: ______________________________

Increase exercise: ☐ YES ☐ NO

Please specify how: ______________________________

Other: ______________________________

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